

Health Benefits At-A-Glance

Benefit	COVA Care You Pay	COVA HDHP You Pay	Kaiser Permanente You Pay
Deductible – per plan year			
• One person	\$200	\$1,200	None
• Two or more persons	\$400	\$2,400	None
Out-of-pocket expense limit – per plan year			
• One person	\$1,500	\$5,000	None
• Two or more persons	\$3,000	\$10,000	None
Doctor's visits			
• Primary care physician	\$25	20% coinsurance after deductible	\$10
• Specialist	\$35		\$10
Hospital services (including surgery)	\$300 per stay	20% coinsurance after deductible	\$100 per admission
Emergency room visits	\$100 per visit (waived if admitted)	20% coinsurance after deductible	\$50 per visit (waived if admitted)
Outpatient diagnostic laboratory, tests, shots and x-rays	10% coinsurance after deductible	20% coinsurance after deductible	\$10 physician, x-ray and diagnostic services \$0 copayment lab, pathology, radiology, diagnostic testing
Prescription drugs – mandatory generic			
• Retail Pharmacy	Up to 34-day supply: \$15/\$20/\$35	20% coinsurance after deductible	Up to 60-day supply • Kaiser On-Site Pharmacy\$10 • Community Pharmacy\$20
• Home Delivery Pharmacy	Up to 90-day supply: \$30/\$40/\$70	20% coinsurance after deductible	Up to 90-day supply • Mail Service\$8
Behavioral health and EAP			
• Inpatient treatment	\$300 per stay	20% coinsurance after deductible	\$100 per admission
• Outpatient visits	\$35	20% coinsurance after deductible	\$10 copayment
• EAP (up to 4 visits per incident)	\$0	\$0	\$0
Wellness services			
• Well child – through age 6, office visits at specified intervals, immunizations, lab and x-rays	\$0	\$0	\$0 (to age 5)
• Routine wellness – age 7 and older			
– Annual checkup visit			
– Primary care physician	\$0	\$0	\$10
– Specialist	\$0	\$0	\$10
– Immunizations, lab and x-rays	\$0 (plan pays up to \$500 per member, per plan year)	\$0	\$0
• Preventive care – one of each per plan year with specific age limits	Includes gynecological exam, Pap test, mammography screening, prostate exam (digital rectal exam), prostate specific antigen test (PSA), and colorectal cancer screening. \$0	\$0	\$0

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Dental benefits			DHMO	OON
• Plan year deductible	\$0	\$25 each (one or two people) \$75 (family)	\$25	\$50
• Plan maximum payment	Up to \$1,200 per member per plan year	Up to \$1,500 per member per plan year	Up to \$1,000 per member for Dental HMO; \$500 for Out-of- Network	
• Diagnostic and preventive	\$0	\$0, no deductible	\$0	25% coinsurance after deductible
• Primary	20% coinsurance	20% coinsurance after deductible	20% coinsurance after deductible	40% coinsurance after deductible
• Complex restorative	See Optional Expanded Dental	50% coinsurance after deductible	50% coinsurance after deductible	60% coinsurance after deductible
• Orthodontics	See Optional Expanded Dental	50% coinsurance after deductible (\$1,500 lifetime maximum)	50% coinsurance after deductible (Age 19 and under; \$1,000 lifetime maximum)	Not covered

COVA Care Additional Coverage Options Benefit	Who Pays	Administrator
Out-of-Network <i>(May be combined with Expanded Dental or Vision, Hearing and Expanded Dental) Applies to Medical and Behavioral Health Services</i>	Plan payment is reduced by 25%. You pay applicable deductible, copayment and/or coinsurance. Provider may balance bill for amount above allowable charge.	Anthem and ValueOptions
Expanded Dental <i>(May be combined with Out-of-Network)</i> <i>Plan pays up to \$1,500 per member per plan year for Basic and Complex Restorative Services</i>		Delta Dental
<ul style="list-style-type: none"> • Complex Restorative (inlays, onlays, crowns, dentures, bridgework) • Orthodontic (\$1,200 lifetime max per member) 	You pay 50% coinsurance, no deductible You pay 50% coinsurance, no deductible	
Vision, Hearing and Expanded Dental <i>(May be combined with Out-of-Network)</i>		
Vision		Anthem
<ul style="list-style-type: none"> • Routine eye exam (once every 24 months) • Eyeglass frames (one set every 24 months) • Lenses (every 24 months) <ul style="list-style-type: none"> • One pair single lenses, or • One pair bifocal lenses, or • One pair trifocal lenses, or • Contact lenses (any kind) 	You pay \$35 Plan pays up to \$75 Plan pays up to \$50 Plan pays up to \$75 Plan pays up to \$100 Plan pays up to \$100	
Hearing		Anthem
<ul style="list-style-type: none"> • Routine hearing exam (once every 48 months) • Purchase of hearing aid(s) and other related hearing services (\$1,200 benefit maximum every 48 months) 	You pay \$35 You pay \$0	
Expanded Dental (see above)		Delta Dental